Appendix A

Somerset Health Protection Assurance Report 2016/17

November 2017

WWW.SOMERSET.GOV.UK

1. INTRODUCTION

The Director of Public Health (DPH) of Somerset County Council has an assurance role in relation to health protection within Somerset. Health Protection seeks to prevent or reduce harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation[1].

The Somerset Health Protection Forum comprises of a number of professional partners who hold health protection responsibilities and has a collective role to provide assurance on behalf of the DPH and the Health and Wellbeing Board.

The purpose of this report is to give an overview of the work that has taken place in Somerset during the past 12 months, key risks and issues, and priorities looking ahead into the next 12 months.

1.1 Health Protection Forum

The purpose of the Somerset Health Protection Forum is to provide assurance on behalf of the population of Somerset that there are safe and effective plans and systems in place to protect population health. This includes communicable disease control, infection prevention and control, emergency planning, environmental health, screening, immunisation, sexual health, air and water quality and safety.

It provides a mechanism for multi-agency working and professional discussion in relation to achieving effective and efficient management of health protection systems and processes across Somerset, including consideration of opportunities for joint action. It is important to note that the Forum does not duplicate operational arrangements for responding to incidents. Rather it provides an opportunity for strategic overview of health protection issues, including the identification of gaps that have arisen during the restructuring of health and public health services, gaps in capacity of the system to respond and challenge to partner organisations in the system.

Within the last report, it was reported that a low attendance at the Health Protection Forum meeting was being experienced due to competing priorities of members. Subsequently, a review of the Health Protection Forum took place early 2017 and members were consulted regarding the future of the group and how to meet the statutory requirements and make this a useful forum for partnership working. This review of the Forum was timely as it coincided with change of Consultant with the responsibility for Health Protection. The review concluded that the Forum should continue quarterly but an annual priority setting meeting with the Director of Public Health should take place where attendance is prioritised. Also, it was agreed that more items of interest would be included on the agenda to ensure that the Forum meetings are relevant to all members.

[1] PHE, *Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public health Functions and Entry to Premises by Local Healthwatch representatives) Regulations 2013*, 2013.

2. LOOKING BACK – 2016/7

2.1 STRATEGIC ACTION PLAN PROGRESS

To ensure that the Health Protection Forum has a focused agenda and forward plan, an annual Strategic Action Plan was developed.

The purpose of this document is to identify the health protection issues that are monitored by the Health Protection Forum and provide updates against the four priorities for 2016/17 as agreed by the Health and Wellbeing Board. These priorities were in addition to the core business of the Health Protection Forum.

Priority 1 **Overall System Resilience**
Priority 2 **Immunisation**
Priority 3 **Air Quality**
Priority 4 **Role of Public Health in responding and adapting to Climate Change**

Priority 1: Overall System Assurance

An area of concern of the Director of Public Health is the overall resilience of the health and social care system and the capacity of system to cope with additional pressures caused by severe weather, outbreaks etc. These concerns are compounded by organisational structural changes, budget cuts in many organisations, population growth and demographic change, particularly in the number of older residents.

During these times of great change, organisations need to be extra vigilant to identify areas of particular pressures and weaknesses within the system. In addition, the assurance role of the Director of Public health is especially critical to ensure that arrangements in Somerset are robust in protecting the health of the population. In the winter of 2016 Somerset had 38 outbreaks of influenza life illness (ILI) in care homes, this tested system resilience.

Key Learning: Recent events have highlighted a consensus that there needs to be more joined up, local planning amongst the health and social care organisations in Somerset and in particular, around multi- casualty planning.

It was agreed that a new planning group called the Somerset Health and Social Care Emergency Planning Group would be established and will have the purpose to ensure effective and robust response plans are in place across the health and care system in Somerset. Membership of this group includes Somerset CCG, Somerset County Council (Public Health, Adult Social Care and Civil Contingencies), Somerset Partnership, Vocare, Taunton and Somerset Acute Trust, and Yeovil Hospital Acute Trust. NHS England who are the lead for health emergency planning across the region are aware and supportive of this work

This group met in October 2017 to discuss mass casualty planning in Somerset and agreed that a framework will be developed that sits across all organisational mass casualty plans and identifies interdependencies.

Priority 2: Immunisation

There are a number of immunisation programmes that are offered to the residents of Somerset, see table 1. In general, uptake of these vaccinations are reaching the target or in line with the national average – see detail in section 2.3. However, it is important that we do not get complacent and continue to monitor progress of all programmes and identify areas that require particular attention. As part of the refreshed Health Protection Forum arrangements, it was agreed that the meetings will include several 'deep dive' assurance sessions on specified programmes.

Childhood	**Vaccine**
	Meningitis B
	Rotavirus
	Diphtheria, tetanus, pertussis, polio and Hib
	Pneumococcal (PCV)
	Hib/MenC booster
	Measles, Mumps and Rubella (MMR)
	Flu (annually aged 2-7)
	HPV
	Tetanus, diphtheria and polio adolescent booster
	MenACWY
Adult	Pneumococcal
	Flu (at risk and over 65s)
	Shingles
	Pertussis (during pregnancy)

Table 1: Current immunisation programmes:

Particular priority was given to the flu programme in 2016/17 and in preparation for the 2017/18 season, due to the complexity of the programme and the importance the programme has in reducing mortality and preventing additional pressures on the health system. The previous uptake data is detailed below in Table 2:

	Somerset (%)			DCIOS (%)			England (%)		
	14/15	15/16	16/17	14/15	15/16	16/17	14/15	15/16	16/17
Over 65s	70.6	70.5	70.5	70.6	69.6	69.1	72.7	71	70.5
At risk under 65s	47.4	42.9	48.5	46.8	43.5	45.5	50.3	45	48.5
Pregnant Women	38.2	42.5	43.9	39.6	41.0	42.3	44.1	42	44.9
Carers	36.9	36.9	46.5	42.7	37.7	39.2	-	-	-
Children (aged 2)	43.3	43.6	46.9	39.6	36.2	41.6	38.5	35.4	39.0
Children (aged 3)	43.8	43.8	46.8	41.2	39.6	42.1	41.3	37.7	41.6
Children (aged 4)	37.2	38.6	40.0	33.6	35.5	34.6	32.9	30.1	33.8
Children – Year 1	-	52.7	65.0	-	-	60.2	-	-	57.6
Children – Year 2	-	53.5	62.6	-	-	56.0	-	-	55.3
Children – Year 3	-	-	60.9	-	-	53.1	-	-	53.3

Table 2: Flu vaccination coverage of target groups

Flu vaccination of care home staff is a particular concern within Somerset, due to the number of influenza like illness (ILI) outbreaks in care homes last year. Within the health and care sectors, vaccinating frontline health and social care staff is vital in reducing the spread of flu to vulnerable service users. Care providers as employers are responsible for arranging immunisations for nursing and care staff as an infection control measure, but uptake is poor.

Ahead of the 2017/18 season, a SW regional Care Home Flu Group met to agree priority actions that can be taken to improve the uptake of the flu vaccination amongst care home staff. Rather than sourcing funding options for care homes, it was agreed that the priority should be on supporting the care homes management to understand why and how they can vaccinate staff. The following actions have been taken:

- Development of a 'Flu toolkit for care homes' which has been designed to give Care homes up-to-date guidance, information, and options for arranging staff flu vaccination https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/care-guidance/
- Promotion of a flu calculator to understand the costs of the vaccine compared to sickness costs.
- Care Home survey to understand the current uptake amongst care homes and their views of vaccinating staff.

Key Learning: Rather than focusing on the funding issues related to vaccinating care home staff against flu, it was felt important to focus on changing attitudes to consider flu vaccination as a business best practice.

Since this piece of work, which occurred prior to the start of the 2017 flu season, NHS England has announced that they will be funding care home staff to receive the flu vaccine but details of how and when this will happen is not currently available (October 2017)

Priority 3: Air Quality

The Somerset Air Quality Steering Group was resurrected in summer 2015 to develop strategic level proposals for action to address traffic-related pollution. Four key priorities were identified in 2016 to develop further.

- To develop a communications strategy including website aiming to inform and influence partners, business and the public.
- Development Control, including cumulative impact.
- Transport, to include highways, local authority and 'grey' fleets, and fleets over which LAs have influence such as partners, taxis and buses.
- Air Pollution Monitoring, in particular oxides of nitrogen and PM2.5.

Capacity constraints in all local authorities have limited progress on these priorities, and on completion of the air quality strategy document. The strategy document, including recommended actions to address these priorities, will be presented to decision makers in the coming months.

To date some progress has been made:

- On starting a website to inform the public, businesses, drivers and developers, etc about what they can do to help improve air quality in Somerset in the choices they make. As an example, a link is provided to independent real world emissions testing results for new cars, which will enable prospective buyers to find out actual emissions, in addition to the lab test results provided by manufacturers. Advice is not limited to vehicles; advice on fuel for wood burning stoves is provided, for example.
- Public health has begun to comment on planning applications for major developments with a view to minimising the need to travel by car in urban areas.
- Environmental health officers have considered how best to monitor small particle pollution ($PM_{2.5}$) and will shortly recommend a portable device is purchased for use across the county to establish a picture of particulate pollution, as at present no such monitoring takes place.

Key Learning: Capacity within the Somerset local authorities is a significant issue when tackling air pollution. Working as a Somerset wide group has identified opportunities where efforts can be shared but benefits are still felt locally.

Nationally, the number of air quality management areas has increased over the last year, and government is again being challenged by pressure group Client Earth in the courts over failing to achieve air quality targets. The draft air quality plan to address nitrogen dioxide pollution advocates a range of measures to local authorities. Ministers had been urged to introduce charges for vehicles to enter a series of clean air zones (CAZs) in new cities, adding to existing plans for such measures in Birmingham, Derby, Leeds, Nottingham, Southampton, and London.

While clean air zones would not be appropriate in Somerset, any that were created in nearby cities such as Bristol and Bath would likely have an impact on Somerset residents and businesses, and thus their vehicle and transport choices.

Somerset had three air quality management areas (Yeovil, Henlade & East Reech) as part of the strategy development data from routine monitoring will be examined.

Priority 4: Role of Public Health in responding and adapting to Climate Change

During this year we have raised awareness of the need and possible actions to achieve reduction in carbon emissions to protect our population from the health implications of climate change. Incremental steps have been taken forward this year, for example, promoting active travel, reviewing the road safety strategy (which is based on the safer streets model) which includes actions around speed and promoting active travel, which will both reduce carbon emissions and identifying a PH Sustainability lead.

There is much to be done in this area and partners of the Health Protection Forum are committed to tackling this issue as individual professionals and organisations, within the limits of organisational capacity.

2.2 HEALTH EMERGENCY PLANNING

2.2.1 Communicable Disease Plans for Somerset

During 2017, there was a big push from the Local Health Resilience Partnership (LHRP) to develop a common plan template for local Communicable Disease Incident and Outbreak Operational Response Plans. It was felt that having a common plan across the LHRP geography would ensure robust and effective response arrangements by improving consistency and therefore reduce confusion and complexity for the organisations that straddle a number of different local authority boundaries e.g. police, fire, the Environment Agency, hospitals and laboratories. This template is due to be signed off by the end of 2017 and an exercise to test the plans is due to take place February 2018.

2.2.2 Health Protection Audit

In 2017, the Avon and Somerset LHRP undertook an audit for PHE on the health protection arrangements across this geography. Reoccurring issues were challenges around prescribing and treatment in care homes (in and out of hours) and prescribing for prophylactic treatment.

2.2.3 Learning from recent terrorist attacks within UK

The LHRP led a small task and finish group to assess all the learning for NHS providers from the Manchester bomb and London attacks. A final report will be presented at the LHRP Tactical Planning Group to launch the associated action plan. This learning will be shared with HPF partners in due course

2.2.4 Exercises

The Forum also has an overview of the various exercises that are scheduled across the organisations to identify appropriate representation and gaps in the exercise schedule and ensure shared learning and strengthened systems focused on Health Protection.

The exercises that have taken place in the past year include:

- Trauma Network Mass Casualty Exercise
- LHRP Health teleconference and cascade exercises

2.3 IMMUNISATIONS

2.3.1 Early childhood vaccinations

Generally Somerset childhood immunisation rates have improved. However, there is still room for improvement with not all programmes reaching 95%. See Table 3 below

The Hexavalent vaccine (6 in 1 offering additional protection against Hep B) commenced in September 2017and training had been made available to local vaccinators over the summer.

46.8% of pre-school children age 2 and 3 received a flu vaccination in 2016/17 compared to 40% national uptake rate.

Indicator	Lower threshold1	Standard2	Geography	2015/16	Q4 2016/17
3.03i - Population vaccination coverage - Hepatitis B (1 year old)			Somerset	100.0	
			England		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	90	95	Somerset	94.9	94.6
			England	93.6	93
3.03iv - Population vaccination coverage - MenC	90	95	Somerset	96.8	83.9
			England	0.0	84.7
3.03v - Population vaccination coverage - PCV	90	95	Somerset	95.3	95.2
			England	93.5	93.3
3.03i - Population vaccination coverage - Hepatitis B (2 years old)			Somerset	100.0	
			England		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	90	95	Somerset	96.4	97.1
			England	95.2	95.1
3.03vi - Population vaccination coverage - Hib / MenC boos	90	95	Somerset	94.1	95.1
			England	91.6	91.3
3.03vii - Population vaccination coverage - PCV booster	90	95	Somerset	94.1	95.3
			England	91.5	91.3
3.03viii - Population vaccination coverage - MMR for one d	90	95	Somerset	93.8	94.6
			England	91.9	91.2
3.03ix - Population vaccination coverage - MMR for one dos	90	95	Somerset	96.2	96.1
			England	94.8	95.1
3.03vi - Population vaccination coverage - Hib / Men C boos	90	95	Somerset	95.7	96.1
			England	92.6	92.8
3.03x - Population vaccination coverage - MMR for two dos	90	95	Somerset	90.8	90.2
			England	88.2	87.4

Table 3: Primary Childhood Vaccination Coverage Data

2.3.2 School aged immunisations

A significantly higher than national rate of children in years 1-3 in Somerset, received a flu vaccine at school in 2016/17. The programme is set to expand in September 2017 with children from reception to year 4 of primary school being offered the vaccine through schools including children in special educational settings. School nursing teams are delivering this programme throughout Somerset and this year Assistant Practitioners will be able to administer the nasal vaccine under the supervision of a qualified nurse.

Somerset achieved higher than national uptake rates for the MenACWY vaccination in students in year 13 and the highest coverage in the South West region. This is attributed to a collaborative approach between PHE and the LA to target communications to schools and colleges.

2.3.3 Immunisations in pregnancy

During 2016/17 43.9% of pregnant women received a flu vaccination, compared to the national average uptake of 44.9%. The vaccinations were administered by maternity and GP staff.

An enhanced programme is in place for 2017/18 with Musgrove Park Hospital, Yeovil District Hospital and Royal United Hospital in Bath offering the flu vaccine. Pertussis will also be offered to pregnant women presenting for routine antenatal care after 16 weeks.

Key Learning: Evidence has shown an increased uptake in pregnancy immunisations when offered during an antenatal appointment. A pilot study at Musgrove Park Hospital resulted in the flu vaccine uptake being doubled when offered during ante-natal clinics, scans and other appointments. All Maternity services supporting Somerset pregnant women are now offering the flu vaccine as part of routine maternity care.

2.3.4 Children Looked After

Progress has been made in the following areas against some of the recommendations in the Health Needs Assessment (HNA) exploring the lower vaccination rate in Children looked after.

- Foster carer training now includes information about vaccinations, including the role foster carers play in ensuring that children are up to date, and a leaflet advising foster carers why immunisations are important. This has been rolled out across Somerset.
- Efforts have also been made to understand why uptake is lower for CLA for vaccinations. In particular, the Rotavirus vaccine has to be received before 24 weeks and cannot be caught up at a later date as the other immunisations can. However, few children are taken into care before 24 weeks and so whether or not most children receive their rotavirus vaccine in time is up to their parents or carers and is outside the influence of the social care system in Somerset. Efforts have also been made to engage young CLA girls to discuss HPV uptake, with the aim of improving understanding of why rates are low but so far this has been declined by the young women themselves.

2.4 SCREENING

The UK National Screening Committee defines screening as “The process of identifying apparently healthy people who may be at increased risk of a disease or a condition so that they can be offered information, further tests and appropriate treatment to reduce their risk and/or complications arising from the disease or condition.”

Because the NHS invites apparently healthy people for screening and screening is based on the principle of do no harm. Healthcare professionals have to ensure individuals receive guidance to help them to make informed choices and support them through the screening process. Each NHS screening programme has a defined set of standards to ensure that services are of a high quality. The NHS and PHE are responsible for the quality assurance of population screening programmes. However, the local authority has a role to play in gaining assurance that the needs of their local population are being met, to identify where there may be issues and to ensure a reduction in inequalities in relation to screening uptake.

There are currently:

- three national cancer screening programmes (breast, bowel and cervical)
- eight non-cancer screening programmes:

- six antenatal and new-born (Foetal Anomaly, Infectious Diseases in Pregnancy, Sickle Cell and Thalassaemia, New-born and Infant Physical Examination, New-born Blood Spot and New-born Hearing)
- two adult (Abdominal Aortic Aneurysm and Diabetic Eye).

2.4.1 Cancer Screening

Breast and cervical cancer screening rates in Somerset remain above the England average, but are below the South West average at 77.4% and 74.7% respectively, compared to the target levels of 80%. Both reflect a declining trend in uptake since 2010. The bowel cancer screening rate stands at 62.2%, above the England and South West rates.

2.4.2 Antenatal Screening

Yeovil District Hospital and Taunton and Somerset Trusts perform well for most indicators within the antenatal screening programmes. The newborn bloodspot screening has improved from 2014/15 to 95.9% now taking it above the England and South West average.

2.4.3 Adult Screening

In relation to the adult screening programmes the Somerset Diabetic Eye (DESP) and the Abdominal Aortic Aneurysm (AAA) Screening programmes continue to perform well, with the latter being the highest rate in the SW at 87.1%.

2.4.4 Screening data

Screening data is available PHOF Health Improvement Indicators (indicators 2.20) and is summarised below in Table 4. More recent data is not complete and so to enable the DPH to fulfil her assurance role, this data quality needs to be worked on during the next year

Indicator	Lower threshold1	Standard2	Geography	2016
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Somerset	77.4
			England	75.5
2.20ii - Cancer screening coverage - cervical cancer (%)	75	80	Somerset	74.7
			England	72.7
2.20iii - Cancer screening coverage - bowel cancer (%)	55	60	Somerset	62.2
			England	57.9
2.20vii - Infectious Diseases in Pregnancy Screening – HIV Coverage (%)	≥ 95%	≥ 99%	Somerset	0.0
			England	99.1
2.20x - Sickle Cell and Thalassaemia Screening – Coverage (%)	≥ 95.0%	≥ 99.0%	Somerset	0.0
			England	99.1
2.20xi - Newborn Blood Spot Screening – Coverage (%)	≥ 95.0%	≥ 99.9%	Somerset	95.9
			England	95.6
2.20xii Newborn Hearing Screening – Coverage (%)	≥ 97%	≥ 99.5%	Somerset	99.7
			England	98.7
2.20xiii - Newborn and Infant Physical Examination Screening – Coverage (%)	≥ 95.0%	≥ 99.5%	Somerset	0.0
			England	94.9
2.20v – Diabetic eye screening - uptake (%)	≥ 70.0%	≥ 80.0%	Somerset	0.0
			England	83.0
2.20iv – Abdominal Aortic Aneurysm Screening – Coverage (%)	≥ 75%	≥ 85.0%	Somerset	87.1
			England	79.9

Table 4: Screening performance data

Key Learning: Nationally cervical screening coverage is declining and is at a 19 year low, with attendance going down across all age groups. Whilst the HPV vaccine protects against two of the main HPV viruses that can cause cervical cancer this accounts for only 70% of cervical cancers and so women still need to be screened. More needs to be done to raise awareness of cervical screening particularly among hard to reach groups. Many sexual health services, including Somerset, no longer provide cervical screening as part of the programme although NHS England are looking to commission this in some areas.

2.5 HEALTHCARE AQUIRED INFECTIONS

2.5.1 *Clostridium Difficile*

A *Clostridium difficile* infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.

In 2016/17 there were a total of 97 cases and the overall *C. difficile* rate for Somerset CCG per 100,000 population was 17.79. This was the lowest rate for CCGs in the South West region

Providers are required to assess each trust attributed case to determine whether the case was linked with a lapse in the quality of care provided to the patient. Under the commissioning contract, lapses of care that contributed to a case will count towards the aggregate number of cases as the basis of which contractual sanctions are calculated

Quarterly multi-disciplinary peer review meetings are held to review providers post infection reviews and agree as to whether or not a lapse of care that could have contributed to case had occurred. The table below shows the figures for 2016/17

Health Care provider	Trajectory for 16/17	Year end figures 16/17	Lapse in care that could have contributed to the case
Somerset Clinical Commissioning Group (SCCG)	106	80	Not assessed
Somerset Partnership NHS Foundation Trust	5	0	0
Taunton and Somerset NHS Foundation Trust (T&SFT)	12	8	1
Yeovil District Hospital NHS Foundation Trust	8	9	3
TOTALS	**131**	**97**	**4**

Table 5: *C. difficile* cases **per organisation in 2016/17**

2.5.2 MRSA Blood Stream Infections

Staphylococcus aureus (S. aureus) is a bacterium that is present on the skin and is the most common cause of localised wound and skin infections. MRSA is a strain of Staphylococcus aureus resistant to many antibiotics

NHS England continues to set healthcare providers the challenge of demonstrating a zero tolerance target for MRSA blood stream infections for patients through a combination of good hygiene, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance.

In 2016/17, there were a total of 7 MRSA bloodstream infections, compared to 6 in the previous year. Following review and submission to NHS England , 5 of these cases were assigned to 'third party' (i.e. no failings of care were identified that contributed to the case). The remaining 2 case were attributed to SCCG (1) and T&SFT (1) and actions put in place to address learning identified.

The total MRSA rate for Somerset CCG per 100,000 population for 2016/17 was 1.28. This was a midrange rate (5th highest out of 12 CCGs) compared to other CCGs in the South west region.

2.5.2.1 Gram Negative Blood Stream infections (GNBSI's)

There is a national ambition to reduce Gram-negative blood stream infections by 50% by March 2021.

For 2017/18 a 10% reduction in all E coli BSIs reported is linked to the Quality Premium. Baseline data for Somerset (Jan – Dec 2016) is 489 cases, and to reach the 10% reduction target Somerset CCG should have no more than 440 cases in 2017/18. This is very challenging, particularly as two of our local acute hospital trusts have some of the highest rates of *E.coli* bloodstream infections in England. We would like assurance that our acute trusts will be complaint with the new mandatory reporting of Gram negative bloodstream infections (GNBSI) and will be addressing this through the HPF

The majority of *E. coli* bloodstream infections occur in the community, and a whole health economy approach is required to achieve the reductions required

A CCG led Somerset county wide reduction action plan and working group is in place, with representation from acute and community trusts, microbiologists, antimicrobial pharmacists and PHE. As urine is the source of 50% of all E coli BSIs, the group has agreed the following 3 key objectives for 2017/18

- Reduce the risk of and improve the management of UTIs
- Reduce prevalence of indwelling urinary catheters
- Improve urinary catheter care

Other key ambitions for 17/18 include maintaining a zero tolerance approach to MRSA BSIs and robust investigation of any case, and achieving the C diff trajectory of no more than 131 C diff cases across SCCG in 2017/18.

2.6 INFECTIOUS DISEASE

2.6.1 Infectious diseases in Somerset

The autumn of 2016 was characterised by an increase in gastrointestinal infections, the majority associated with norovirus outbreaks, although not to the same extent as in the previous year. Measles cases had declined in October after an outbreak in the South West over the summer of 2016 and from November, no further cases were confirmed.

Over the winter 38 outbreaks of flu were reported in Somerset Care Homes, this is higher number than in recent years. This was a national trend and despite the vaccine being a good match for circulating viruses and having a reasonable uptake of vaccine in the elderly, the vaccine provided poor protection. It was evident that there were very poor levels of vaccine uptake in care home staff; this has been addressed by the wider health community and recently a national initiative has been announced to enable care home staff to be immunised by the NHS.

In 2016/7 avian flu in migrating birds was also of particular concern and there were restrictions placed on domestic flocks for much of the quarter. There were three incidents of avian flu in birds in Somerset.

In the Spring, norovirus outbreaks increased again and we saw what is now a usual increase in cases of scarlet fever. Two clusters of cryptosporidiosis were investigated with 11 and 12 cases. Both were associated with visits to educational farms. Recommendations were made regarding handing of the animals, hand washing and cleaning.

Over the year there were 16 confirmed cases of meningococcal disease; ten were group W135, 4 Group B and one Group Y (one untyped). Of the cases with W135 only one was a young person under 25 years. Two pairs of meningococcal disease were investigated however they were not considered to be linked.

We have seen an increase in TB in recent years, although numbers remain very small. The three-year average number of TB case notifications in Somerset from 2014-2016 is 10 per year. The rate is 1.9 /100,000 (1.3-2.7 95% CI) compared with 5.1 (4.8-5.5) in the South West. In 2017 two complex cases have involved management by multi agency incident teams over a period of many months.

2.6.2 Hepatitis

During 2016/17 there was a national outbreak of Hepatitis A and a cluster outbreaks of Hepatitis B passed on through sexual activity, particularly but not exclusively amongst men who have sex with men (MSM).

Both outbreaks impacted areas in the South West region, including Somerset, and a number of actions were identified to control the outbreak. This included promoting vaccination in sexual health services targeting MSM through a successful social media campaign. However, there have been global shortages of vaccines for both Hepatitis A and B and consequently Public Health England have revised their immunisation recommendations to ensure access for high risk groups such as MSM and injecting drug users.

3 OVERALL SYSTEM ASSURANCE

In summary, the Director of Public Health has a high degree of assurance that measures are in place to protect the health of the Somerset population. There are still a number of areas of concern, which are captured on the SCC JCAD risk register system. This details actions to be taken and how individual situations are being managed.

4 THE AGREED PRIORITIES FOR 2017/18

As a result of the priority setting meeting held in September by the HPF with the Direct of Public Health, the following priorities were agreed

1. **System resilience**

System resilience remains the main area of concern of the Director of Public Health. There are still some major system changes on the horizon that impacts on the overall resilience of the health system and its ability to respond robustly to outbreaks and incidents.

In an attempt to ensure Somerset is able to respond robustly to outbreaks and incidents, particular focus will be given to the establishment of the Somerset Health and Social Care Emergency Planning Group. This group will have the purpose to ensure that response plans across Somerset are joined up and organisations work collaboratively to achieve resilience.

In addition, the Somerset Communicable Disease Incident and Outbreak Operational Response Plan will be finalised and tested in line with the PHE framework and plan template.

2. **Flu Immunisation**

Preparing for the 2018/19 flu season will continue to be a priority for the Health Protection Forum due to the significant impact a significant flu season can have on the entire health and social care system. The health and social care system is already under great pressure during a regular winter season so it is vital that all arrangements are in place to ensure that there is an improved uptake of the flu vaccine (especially amongst frontline health and social care workers) and organisations are prepared and resilient in the event of an outbreak.

3. **Air Quality**

A great amount of progress has been made in recent years with regards to air quality in Somerset. The Somerset Air Quality Steering Group has been meeting regularly to ensure the sign off of the Somerset-wide Air Quality Strategy and progressing with work streams in a joined up and collaborative manner. It is a priority that this momentum is continued to ensure that air pollution is tackled in a consistent and effective way across Somerset.

4. **TB**

TB has previously been a priority for the Health Protection Forum during 2014/15. This priority focused on the rollout of the Collaborative TB Strategy for England 2015-20 and establishing the TB Network for the Southwest. This TB Network continues to function with regular cohort meetings to discuss cases and outbreaks in detail, however, Somerset clinicians struggle to engage with these due to timing and location.

The TB strategy and action plan have progressed with a prioritisation exercise held at the network meeting in March 2017. Further work in Somerset is needed with commissioners to involve them in agreeing and implementing the action plan and ensuring there is equity of access to effective diagnosis, treatment, contact tracing and follow up of all patients, according to their needs.

5 CONCLUSION

In conclusion, the Health Protection Forum continues to develop and deliver against their statutory function, whilst also improving systems to protect Somerset residents health. We are seeking the Health & Well-Being Board's approval of the chosen priorities; system resilience, influenza, air quality and tuberculosis. And the commitment of their teams to furthering the impact we can have collectively on our populations health and improving outcomes